

Ulysses in Minnesota: First Steps Toward a Self-Binding Psychiatric Advance Directive Statute

Roberto Cuca

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NOTES

ULYSSES IN MINNESOTA: FIRST STEPS TOWARD A SELF-BINDING PSYCHIATRIC ADVANCE DIRECTIVE STATUTE

Medical jurisprudence in the United States has grown increasingly supportive of the right of patients to control their own medical treatment. Following the lead of the common law, many states have enacted statutes protecting patients' rights. Living wills,¹ health care proxies,² and health care powers of attorney³ are statutory creations that enable patients to control their treatments even when they are unconscious and therefore incompetent to make treatment decisions. Although such statutes have existed for more than a decade, analogous statutes enabling those with mental illnesses⁴ to plan for their treatments have been slow in arriving.

Many patients with recurrent mental illnesses experience periods of lucidity alternating with relapses into incompetence.⁵ For some, the mental illness manifests itself in part through the refusal of all treatment offers and a denial of the disease.⁶ As a result, these patients must undergo an often lengthy commitment process before their physicians can administer medication that may return them to lucidity.⁷ The hearing process and attendant hospitalization can be very costly for the patient, the patient's family, and the state.⁸ In

¹ See discussion *infra* part I.A.2.a.

² See discussion *infra* part I.A.2.b.

³ See discussion *infra* part I.A.2.c.

⁴ The American Psychiatric Association has expressed its preference for phrases such as "those with mental illnesses" rather than "the mentally ill:"

A common misconception is that a classification of mental disorders classifies people, when actually what are being classified are disorders that people have. For this reason, the text . . . avoids the use of such expressions as "a schizophrenic" or "an alcoholic," and instead uses the more accurate, but admittedly more cumbersome, "a person with Schizophrenia" or "a person with Alcohol Dependence."

AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS at xxiii (3d ed. revised 1987) [hereinafter DSM-III-R].

⁵ One example of a disease that affects patients in this way is Schizophrenia. DSM-III-R, *supra* note 4, at 190.

⁶ Negativeness is a common feature of Catatonic Schizophrenia. DSM-III-R, *supra* note 4, at 196. Denial of disease often accompanies such delusional illnesses. See DSM-III-R, *supra* note 4, at 199 for a description of delusional disorders.

⁷ Marilyn K. Rosenson & Agnes M. Kasten, *Another View of Autonomy: Arranging for Consent in Advance*, 17 SCHIZOPHRENIA BULL. 1, 5 (1991).

⁸ Issue Topic, *The Cost of Schizophrenia*, 17 SCHIZOPHRENIA BULL. 363 (1991).

addition, the illness can impose great emotional burdens on everyone involved.⁹

As a solution to such problems, some commentators have suggested the use of a "Ulysses contract,"¹⁰ which would allow a physician to ignore a patient's disease-induced refusal and administer medication.¹¹ The "contract" serves as a record of the patient's pre-incompetent consent to the treatment and cannot be revoked by the patient during her incompetence. Furthermore, the Ulysses contract overrides any subsequent incompetent treatment refusal, thereby allowing the patient to commit herself to a chosen course of medical care. This contract involves unusually extensive self-binding, for which the only effective method of enforcement would be specific performance. Most commentators have concluded that courts will not enforce such a contract absent enabling legislation.¹²

Such legislation is sorely needed by those with recurring mental illnesses. By consenting to treatment before a relapse occurs, a patient with a mental illness can avoid the delays, costs, and unnecessary hospitalization that usually accompany a court order for treatment. Additionally, a Ulysses document allows the patient to control her own treatment without needing to designate another person to make decisions for her. Such self-reliance and autonomy is implicitly valued in the many decisions that have recognized the right of a patient to control her own treatment.¹³

⁹ Evelyn Smith, *First Person Account: Living with Schizophrenia*, 17 SCHIZOPHRENIA BULL. 689 (1991).

¹⁰ The contract gets its name from the hero Ulysses who was advised to bind himself to his ship's mast and to order his crew to ignore his cries for release:

[L]isten to what I say, and God himself shall help you to remember. First you will meet the Sirens, who cast a spell on every man who goes their way. Whoso draws near unwarned and hears the Sirens' voices, by him no wife or little child shall ever stand, glad at his coming home; for the Sirens cast a spell of penetrating song, sitting within a meadow. But by their side is a great heap of rotting human bones; fragments of skin are shriveling on them. Therefore sail on, and stop your comrades' ears with sweet wax kneaded soft, that none of the rest may hear. As for yourself, if you desire to listen, see that they bind you hand and foot on the swift ship, upright upon the mast-block, — round the mast let the rope's ends be wound, — that so with pleasure you may hear the Sirens' song. But if you should entreat your men and bid them set you free, let them thereat with still more fetters bind you fast.

HOMER, *THE ODYSSEY* 405 (George H. Palmer trans., Houghton & Mifflin 1886) (n.d.).

¹¹ See Timothy Howell et al., *Is There a Case for Voluntary Commitment?*, in CONTEMPORARY ISSUES IN BIOETHICS 163 (Tom L. Beauchamp & LeRoy Walters eds., 2d ed. 1982).

¹² See Rebecca S. Dresser, *Bound to Treatment: The Ulysses Contract*, HASTINGS CENTER REP., June 1984, at 13 [hereinafter Dresser, *Bound to Treatment*]; Rebecca S. Dresser, *Ulysses and the Psychiatrists: A Legal and Policy Analysis of the Voluntary Commitment Contract* 16 HARV. C.R.-C.L. L. REV. 777, 795 (1982) [hereinafter Dresser, *Ulysses and the Psychiatrists*].

¹³ See discussion *infra* part I.A.1.

Minnesota took the first step towards enacting a Ulysses enabling statute in 1991 when its legislature passed an amendment to the state's psychiatric treatment laws creating the "advance psychiatric directive."¹⁴ The new statutory scheme allows a patient to use such a directive to refuse or consent, in advance, to intrusive mental health treatment.¹⁵ The amendment also appears to authorize the use of a "Ulysses directive," which would have the same effect as a Ulysses contract.¹⁶ If this were true, Minnesota's statute would be the first Ulysses enabling statute in the country, providing a prototype for other states to follow.

This Note argues that the Minnesota statute, which could have guided the drafting of similar laws in the rest of the nation, fails to meet the special needs of patients with recurring mental illnesses. The statute, as applied under current medical decision making case law, does not allow a patient to bind herself prospectively to a course of treatment in anticipation of making a later, incompetent treatment refusal.¹⁷ Its primary weaknesses are in failing to specifically empower physicians to make determinations of incompetency, and in not employing the safeguards necessary for such a delegation. With some changes, however, the Minnesota statute could be an effective Ulysses directive enabling statute and a model for other states.

Part I of this Note reviews the evolution of medical jurisprudence and the emergence of advance directive statutes. Part II examines the Minnesota advance psychiatric directive statute in light of current case law, and concludes that the combined statutory and case law does not permit the drafting of a Ulysses directive. Finally, Part III proposes changes to the statute that would allow patients suffering from recurring mental illnesses to control their treatment in the face of expected treatment refusals. With these changes in place, Minnesota's statute would stand as a model for other states wishing to adopt laws fully enabling Ulysses directives.

¹⁴ MINN. STAT. § 253B.03, subd. 6b-d (Supp. 1993).

¹⁵ "A competent adult may make a declaration of preferences or instructions regarding intrusive mental health treatment. These preferences or instructions may include, but are not limited to, consent to or refusal of these treatments." MINN. STAT. § 253B.03, subd. 6d(a) (Supp. 1993). An "intrusive mental health treatment" includes electroshock therapy and neuroleptic medication. § 253B.03, subd. 6b.

¹⁶ This Note will use the term "Ulysses directive" to refer to a document enabled by a statute that provides for self-binding to a chosen course of treatment in the face of anticipated subsequent treatment refusals. The term "Ulysses contract" will be used to refer to such documents not enabled by a statute.

¹⁷ See discussion *infra* part 11.B.

I

MEDICAL JURISPRUDENCE BEFORE THE ULYSSES DIRECTIVE

This section will examine the development of patient self-determination law to the present. First, this section will review medical jurisprudence and its increasing regard for the rights of patients. Next, it will examine the treatment control problems that have motivated the call for the Ulysses contract. Finally, this section will introduce Minnesota's response to such problems through its advance psychiatric directive statute.

A. The Move Toward Patient Self-Determination

A great degree of physician paternalism marked the early practice of medicine.¹⁸ The role of the physician was to decide for the patient which treatment was best.¹⁹ Societal changes gradually led to greater demands for patient participation in and control of treatment decision-making;²⁰ legislatures responded by enacting laws that recognize and increase patient autonomy.

1. Case Law Developments

United States medical jurisprudence during the twentieth century has focused on the balance of power in the physician-patient relationship.²¹ Until the early part of this century, physicians played a paternalistic role, making most or all treatment decisions for the patient.²² Consent was limited to mere approval of the physician's suggested treatment.²³ Courts have changed this balance, giving patients increased control. In 1914, in one of the earliest treatment decision cases, *Schloendorff v. Society of N.Y. Hospital*,²⁴ Judge Cardozo formulated the rule that still informs such cases today: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body"²⁵

A weakening of the two limits of the *Schloendorff* rule—age and competence—has characterized the development of self-determination in medical treatment decisions. Although the courts have given

18 See Jay Katz, *Informed Consent—A Fairy Tale?*, 39 U. PITT. L. REV. 137, 140 (1977).

19 See *id.*; Ezekiel J. Emanuel & Linda L. Emanuel, *Four Models of the Physician-Patient Relationship*, 267 JAMA 2221 (1992).

20 See Katz, *supra* note 18, at 149-164; JAMES C. MOHR, DOCTORS AND THE LAW 164-79 (1993).

21 See Katz, *supra* note 18, at 143-154.

22 See Katz, *supra* note 18, at 143-154.

23 See Katz, *supra* note 18, at 144; Emanuel & Emanuel, *supra* note 19.

24 105 N.E. 92 (N.Y. 1914).

25 *Id.* at 93.

children some say over their treatment,²⁶ the greatest expansion has occurred in the area of self-determination for patients with mental illnesses.²⁷ *Rennie v. Klein*,²⁸ decided in 1983, is one of the earliest cases recognizing that patients with mental illnesses, including those involuntarily committed, have a right to refuse treatment based on due process and privacy rights. This right is qualified where the patient constitutes a danger to himself or others.²⁹ The Massachusetts Supreme Court's 1983 decision in *Rogers v. Commissioner of the Department of Mental Health*³⁰ underscored the lessons of *Rennie* by holding that the right of a patient with a mental illness to control his own treatment is equal to that of any other patient, until the courts determine him to be incompetent.³¹ The court held that only when the patient presents an immediate danger to himself or to others may the state treat the objecting patient without first obtaining a court order.³² More recent decisions have established that the law accords weaker procedural protections to the treatment refusal rights of imprisoned patients with mental illnesses than it does to other patients with mental illnesses.³³ However, such patients still possess a limited right of refusal, and a related right to be informed of treatment alternatives.³⁴

Although not dealing with mental health treatment control, the Supreme Court's 1990 decision in *Cruzan v. Director, Missouri Department of Health*³⁵ affirmed many of the previously established rules and policies underlying patient autonomy. The Court determined that a state's requirement of clear and convincing evidence of an incompetent patient's treatment wishes before removal of life-sustaining treatment does not violate the Federal Constitution.³⁶ The patient has a right to decide whether to continue treatment, but this right must be balanced against the state's interest in verifying the

²⁶ See Walter J. Wadlington, *Consent to Medical Care for Minors*, in CHILDREN'S COMPETENCE TO CONSENT 57-69, 73-74 (Gary B. Melton et al. eds., 1983); SAMUEL M. DAVIS & MORTIMER D. SCHWARTZ, CHILDREN'S RIGHTS AND THE LAW 79-98 (1987).

²⁷ See MOHR, *supra* note 20. For a thorough account of the right to refuse antipsychotic drugs, see Dennis E. Cichon, *The Right to "Just Say No": A History and Analysis of the Right to Refuse Antipsychotic Drugs*, 53 LA. L. REV. 283 (1992).

²⁸ 720 F.2d 266 (3d Cir. 1983).

²⁹ *Id.* at 269.

³⁰ 458 N.E.2d 308 (Mass. 1983).

³¹ *Id.* at 314.

³² *Id.* at 321-22.

³³ *Washington v. Harper*, 494 U.S. 210 (1990).

³⁴ *White v. Napoleon*, 897 F.2d 103, 113 (3d Cir. 1990).

³⁵ 497 U.S. 261 (1990).

³⁶ *Id.* at 280.

incompetent patient's wishes.³⁷ In such situations living wills provide the easiest means of meeting this standard of proof.³⁸

2. *Statutory Developments*

In an effort to systemize these common law developments in treatment control, many states have enacted statutes creating devices that enable patients to control their medical treatment. The statutes of longest standing are those that transfer decision-making power to another person—the health care proxy, durable power of attorney, and durable health care power of attorney. More widely known and used is the living will, a document that serves to preserve the competent wishes and intentions of the drafter regarding the withdrawal or continuation of life-sustaining treatment in cases of terminal illness or irreversible coma.³⁹ Because these statutes are among the most developed in the area of treatment control, they highlight the necessary elements of sound advance directive legislation.

a. *Living Wills*

Forty-three jurisdictions in the United States now have some form of living will statute,⁴⁰ a few of which are based on the model

³⁷ *Id.* at 280-82.

³⁸ See discussion of living wills *infra* part I.A.2.a.

³⁹ All living will statutes are limited to these circumstances. See UNIFORM RIGHTS OF THE TERMINALLY ILL ACT § 3, 9B U.L.A. 615 (1989) (limiting itself to terminal conditions only); *infra* note 40.

⁴⁰ Currently, forty-two states and the District of Columbia have a "living will," "death with dignity," "natural death," or "right to die" statute: ALA. CODE §§ 22-8A-1 to -10 (1990); ALASKA STAT. §§ 18.12.010-.100 (1991); ARIZ. REV. STAT. ANN. §§ 36-3201 to -3211 (1986 & Supp. 1992); ARK. CODE ANN. §§ 20-17-201 to -218 (Michie 1991); CAL. HEALTH & SAFETY CODE §§ 7185-7195 (West Supp. 1993); COLO. REV. STAT. ANN. §§ 15-18-101 to -113 (West 1987 & Supp. 1992); CONN. GEN. STAT. ANN. §§ 19a-570 to -580c (West Supp. 1993); DEL. CODE ANN. tit. 16, §§ 2501-2509 (1983); D.C. CODE ANN. §§ 6-2421 to -2430 (1989); FLA. STAT. ANN. §§ 765.301-.310 (West Supp. 1993); GA. CODE ANN. §§ 31-32-1 to -12 (1991 & Supp. 1992); HAW. REV. STAT. ANN. §§ 327D-1 to -27 (Michie 1991 & Supp. 1992); IDAHO CODE §§ 39-4501 to -4509 (1985 & Supp. 1992); ILL. ANN. STAT. ch. 110 1/2, para. 701-710 (Smith-Hurd Supp. 1991); IOWA CODE ANN. §§ 144A.1-.11 (West 1989 & Supp. 1993); KAN. STAT. ANN. §§ 65-28,101 to -28,109 (1985); KY. REV. STAT. ANN. §§ 311.622-.644 (Baldwin 1992); LA. REV. STAT. ANN. §§ 40:1299.58.1-.10 (West 1992); ME. REV. STAT. ANN. tit. 18-A, §§ 5-701 to -714 (West Supp. 1992); MINN. STAT. ANN. §§ 145B.01-.17 (West Supp. 1993); MISS. CODE ANN. §§ 41-41-101 to -121 (Supp. 1992); MO. ANN. STAT. §§ 459.010-.055 (Vernon 1992); MONT. CODE ANN. §§ 50-9-101 to -206 (1992); NEV. REV. STAT. ANN. §§ 449.535-.690 (Michie 1991); N.H. REV. STAT. ANN. §§ 137-H:1 to -H:16 (1990 & Supp. 1992); N.M. STAT. ANN. §§ 24-7-1 to -10 (Michie 1991); N.Y. PUB. HEALTH LAW §§ 2960-2979 (McKinney Supp. 1993); N.C. GEN. STAT. §§ 90-320 to -323 (1990); OKLA. STAT. ANN. tit. 63, §§ 3101.1-.16 (West Supp. 1993); OR. REV. STAT. §§ 127.605-.650 (1990 & Supp. 1992); S.C. CODE ANN. §§ 44-77-10 to -160 (Law. Co-op. Supp. 1992); TENN. CODE ANN. §§ 32-11-101 to -112 (Supp. 1992); TEX. HEALTH & SAFETY CODE ANN. §§ 672.001-.021 (West 1992); UTAH CODE ANN. §§ 75-2-1101 to -1118 (1993); VT. STAT.

drafted by the American Bar Association Commission on Uniform Laws.⁴¹ Many of these statutes include a statement of legislative purpose reflecting Judge Cardozo's holding in *Schloendorff*,⁴² that every competent adult has the right to accept or reject medical treatment.⁴³ Despite this expansive statement of purpose, all of these statutes limit their application to the regulation of life-sustaining treatments in cases involving terminal illness or irreversible vegetative state.⁴⁴

Some living will statutes provide model wills with boxes patients can check to request or reject particular treatment directions;⁴⁵ others allow the drafter to detail those treatments to be accepted or rejected.⁴⁶ Almost all statutes permit revocation of the living will by act or statement regardless of the drafter's mental or physical condition.⁴⁷ This reflects the belief that it is better to err against a patient's wishes by continuing, rather than withdrawing, life sustaining treatment. Similarly, a few states provide for the invalidation of the living will if, and for as long as, a patient is preg-

ANN. tit. 18, §§ 5251-5262 (1987); VA. CODE ANN. §§ 54.1-2981 to -2993 (Michie 1991 & Supp. 1992); WASH. REV. CODE ANN. §§ 70.122.010-.905 (West 1992 & Supp. 1993); W. VA. CODE §§ 16-30-1 to -13 (1991 & Supp. 1992); WIS. STAT. ANN. §§ 154.01-.15 (West 1989 & Supp. 1992); WYO. STAT. §§ 35-22-101 to -109 (1988). See also Act to amend [recodify] the Code Concerning health and hospitals, 1993 Ind. Legis. Serv. 2-1993, § 19 (to be codified at IND. CODE §§ 16-36-4-1 to -21); Health Care Decision Act, 1993 Md. Laws 372 (to be codified at MD. CODE ANN., HEALTH-GEN §§ 5-601 to -618).

⁴¹ UNIFORM RIGHTS OF THE TERMINALLY ILL ACT §§ 1-18, 9B U.L.A. 609-23 (1989).

⁴² 105 N.E. 92 (N.Y. 1914).

⁴³ "The Legislature finds an adult person has the fundamental right to control the decisions relating to the rendering of his or her own medical care." CAL. HEALTH & SAFETY CODE § 7185.5(a) (West Supp. 1993). See also ALA. CODE § 22-8A-2 (1990); COLO. REV. STAT. ANN. § 15-18-102(1)(a) (West 1987); DEL. CODE ANN. tit. 16, § 2502 (1983); FLA. STAT. ANN. § 765.102 (West Supp. 1993); GA. CODE ANN. § 31-32-1(d) (1991 & Supp. 1993); HAW. REV. STAT. ANN. § 327D-1 (Michie 1991); IDAHO CODE § 39-4502 (1993); IND. CODE ANN. § 16-8-11-1 (Burns 1990); IOWA CODE ANN. § 144A.1 (West 1989); LA. REV. STAT. ANN. § 40:1299.58.1(A)(1) (West 1992); N.H. REV. STAT. ANN. § 137-H:1 (1990 & Supp. 1992); N.Y. PUB. HEALTH LAW § 2960 (McKinney Supp. 1993); N.C. GEN. STAT. § 90-320(a) (1990); S.C. CODE ANN. § 44-77-10 (Law. Co-op. Supp. 1992); UTAH CODE ANN. § 75-2-1102(2) (1993); VT. STAT. ANN. tit. 18, § 5251 (1987); WASH. REV. CODE ANN. § 70.122.010 (West 1992 & Supp. 1993).

⁴⁴ Some statutes also allow the removal of artificial nourishment or specifically exclude palliative care from the list of treatments that can be controlled through a living will. See *supra* note 40.

⁴⁵ Because of the small range of decisions the patient can make, and the low risk of misinterpretation of such decisions, living wills can easily be designed as box-checking forms. Some state statutes provide a sample form in which the drafter identifies those treatments he does or does not want to receive by marking them on a model form. See ALASKA STAT. § 18.12.010(c) (1986).

⁴⁶ See, e.g., ALA. CODE § 22-8A-4 (1990); CAL. HEALTH & SAFETY CODE § 7186.5(b) (West Supp. 1993).

⁴⁷ See UNIFORM RIGHTS OF THE TERMINALLY ILL ACT § 4, 9B U.L.A. 616 (1989); *supra* note 40.

nant.⁴⁸ Commentators have vigorously questioned the constitutionality of such provisions.⁴⁹

Generally, the drafter of a living will is limited by the terms of the living will statute, which narrows the range of decisions to be made.⁵⁰ Living will statutes govern a limited number of situations and provide only a few treatment options—to withdraw or continue feeding, to withdraw or continue mechanical support, or to resuscitate or not in the event of an emergency. The patient is presented with a hypothetical scenario in which he is unconscious, and in which two physicians have determined that he is either terminally ill or in an irreversible coma. The patient must then decide whether, under such circumstances, he would want his life artificially prolonged. He confronts a fairly predictable outcome in the event that his physician follows the living will, and he is likely to have established feelings about the desirability of each alternative. Thus the drafter might decide that he would not want to be resuscitated from a heart attack during a persistent vegetative state but that he would want to continue to receive nourishment and hydration. A physician presented with a living will can feel confident that he understands the drafter's intent, and the drafter can expect that the document will not be misinterpreted.⁵¹

b. *Health Care Proxy*

Living will statutes often provide for the designation of a health care proxy—a person designated to oversee the enactment of the incompetent patient's wishes.⁵² This increases the flexibility of the living will and makes it more likely that a patient's wishes will be

⁴⁸ See, e.g., IND. CODE ANN. § 16-8-11(d) (Burns 1990); MINN. STAT. § 145B.13(3) (Supp. 1993).

⁴⁹ These commentators have argued that under *Roe v. Wade*, 410 U.S. 113 (1975), the state may not interfere with a woman's medical decisions until the fetus reaches viability. See Joan Mahoney, *Death with Dignity: Is there an Exception for Pregnant Women?*, 57 UMKC L. REV. 221 (1989); Elizabeth C. Benton, Note, *The Constitutionality of Pregnancy Clauses in Living Will Statutes*, 43 VAND. L. REV. 1821 (1990); Molly C. Dyke, Note, *A Matter of Life and Death: Pregnancy Clauses in Living Will Statutes*, 70 B.U. L. REV. 867 (1990); Janice MacAvoy-Snitzer, Note, *Pregnancy Clauses in Living Will Statutes*, 87 COLUM. L. REV. 1280 (1987); Hope E. Matchan & Kathryn E. Sheffield, Comment, *Adding Constitutional Depravation to Untimely Death: South Dakota's Living Will Pregnancy Provision*, 37 S.D. L. REV. 388 (1992).

⁵⁰ All living will statutes limit their application to either or both irreversible coma (or vegetative state) and terminal illness. See *supra* notes 39-40.

⁵¹ But see Hastings Center, Case Study, *Whether No Means No*, HASTINGS CENTER REP., May-June 1992, at 26 (presenting a situation in which an express refusal of all life-sustaining treatments is not clearly applicable).

⁵² See *supra* note 40.

fulfilled.⁵³ The health care proxy's power is restricted to those situations in which a living will may apply: cases of terminal illness or irreversible coma.⁵⁴ As with a living will, a patient can revoke the proxy assignment at any time, regardless of the patient's physical or mental condition.⁵⁵ The reasons for these limitations are similar to those behind the revocation power of the living will: to achieve most completely the wishes of the patient, while erring, if at all, by continuing, rather than withdrawing, treatment.⁵⁶

Most writers encourage the nomination of a health care proxy when a living will is created.⁵⁷ The proxy is someone with whom a physician can consult in cases involving unforeseen circumstances.⁵⁸ The proxy, generally someone who knows the patient well, can also help resolve any ambiguities in the living will by providing insight into the patient's attitudes towards particular treatment options.⁵⁹

The health care proxy plays a fairly limited role. She must make decisions that would accord with the patient's wishes as expressed in any advance directive documents and with her knowledge of the patient.⁶⁰ Furthermore, if the drafter desires, he can limit the proxy's power by expressly withholding in the appointing document the authority to act in specified situations.⁶¹

c. *Durable Power of Attorney and Durable Health Care Power of Attorney*

Two decision-making options with more general application than the health care proxy are the durable power of attorney and the durable health care power of attorney. The former is a wide-ranging power that allows the holder to make any decision that the grantor of the power could have made.⁶² The latter is limited in scope to decisions concerning the health care of the grantor.⁶³

⁵³ See Lewis M. Silverman & Manette Dennis, Comment to Case Study, *Whether No Means No*, HASTINGS CENTER REP., May-June 1992, at 26-27 (describing how the proxy can help clarify a patient's wishes).

⁵⁴ See, e.g., CONN. GEN. STAT. ANN. §§ 19a-570 to -580 (West Supp. 1993).

⁵⁵ *Id.*

⁵⁶ See Dresser, *Ulysses and the Psychiatrists*, *supra* note 12.

⁵⁷ See Howard L. Sollins, *Advance Medical Directives*, MD. B.J., Mar./Apr. 1991, at 7, 10-11; *Advance Medical Directives*, WIS. LAW., Oct. 1991, at 17.

⁵⁸ Most proxy statutes recommend that the proxy be a family member or a close friend who is likely to know the patient's treatment preferences.

⁵⁹ For example, the decision to remove Nancy Cruzan's life support and artificial feeding was based not on a living will, but on testimony by friends and co-workers that she had said that she "would not want to live should she face life as like a 'vegetable'." Cruzan v. Director, Missouri Dep't of Health, 497 U.S. 261, 285 (1990).

⁶⁰ See, e.g., CONN. GEN. STAT. ANN. §§ 19a-570 to -580 (West Supp. 1993).

⁶¹ *Id.*

⁶² See, e.g., COLO. REV. STAT. ANN. § 15-1-1303 (West Supp. 1992).

⁶³ See, e.g., IND. CODE ANN. § 16-8-12-6 (Burns 1992).

In a jurisdiction that has only the more general power of attorney, the grantor can create a health care power of attorney by using the general appointing document to limit the power to the field of health care. A jurisdiction with statutes supporting both powers provides for no extra attorney power, but simply facilitates the limitation of the general power to health decisions.

The durable health care power of attorney gives the holder of the power the same treatment decision making rights as the grantor.⁶⁴ Generally, the statutes require that the holder exercise her power in conformance with the grantor's expressed desires.⁶⁵ The powers of attorney embrace all treatment decisions that the patient could have made. This includes the power to revoke the grantor's independent treatment instructions, making it possible to subvert the patient's intent by revoking any advance treatment directives, and then making treatment decisions that the directives would have prohibited.⁶⁶ In contrast, the powers of a health care proxy are not as susceptible to abuse because they are explicitly limited to the terms of the grantor's living will.⁶⁷

To prevent this misuse of the power of attorney, the grantor should limit the power holder through restrictions in the granting document. For example, a patient with religious prohibitions against accepting certain treatments might limit the health care attorney's power to the rejection of these treatments. These limitations can either repeat the orders included in any advance directive, withhold the power to revoke any advance directives, or both.

Despite many similarities, powers of attorney differ from health care proxies in that the granted power is more extensive. The holder of a durable health care power of attorney may make decisions in all medical cases, whereas the health care proxy under a living will may only make decisions concerning the use of life-sustaining treatment.⁶⁸ However, durable powers of attorney are advisable for the same reasons that health care proxies are—they increase the flexibility of the advance directive and make it more likely that all decisions will be made in accordance with the general treatment wishes of the patient.

⁶⁴ See, e.g., IND. CODE ANN. § 16-8-12-6 (Burns 1992).

⁶⁵ *Id.* at (h)(1).

⁶⁶ For an example of the ways in which power holders can misuse their powers, see Dakin Williams, *Where They Can Force People to Stay*, in *BLUE JOLTS* 23 (Charles Steir ed., 1978).

⁶⁷ See discussion *supra* part I.A.2.b.

⁶⁸ The proxy under the Minnesota advance psychiatric directive statute is empowered to make decisions regarding the use of intrusive mental health treatment—only those decisions that can be made in an advance psychiatric directive. § 253B.03, subd. 6d(b).

Although powers of attorney give patients with mental illnesses one method of controlling their treatment while incompetent, such powers require an intermediary to make or enforce decisions, and thus do not provide the self-sufficiency and independence inherent in a documentary advance directive. The empowerment of the document-writing patients is an important reason to make Ulysses directives available to patients with mental illnesses.

B. Problems of Patients with Mental Illnesses to be Remedied by a Directive Statute

Any directive power or document used to dictate treatment will serve one or both of two purposes. The first, avoidance of unwanted treatment, is general to medical treatment decision-making. The second, overcoming disease-motivated refusal of competently requested treatment, is specific to patients with mental illnesses.

1. *Unwanted Treatment*

Because mental health treatments can be unpleasant⁶⁹ and can cause severe side effects,⁷⁰ a patient who has received such a treatment might wish to prevent its use in the future.⁷¹ The patient might also seek to specify alternative treatments that she would be willing to accept in lieu of the prohibited one. To enact the patient's wishes in such a case, some writers have proposed the "psychiatric will."⁷² Such a document, modeled on the living will, would contain directives that prevent physicians from using designated treatments on the incompetent patient.⁷³

In 1992, a patient in Minnesota drafted the first psychiatric will in the country after she became unhappy with her treatment, which had included the use of chemical and physical restraints.⁷⁴ By drafting such a will she was able to ensure that she would not be heavily sedated or physically restrained during her next episode of incom-

⁶⁹ Electro-convulsive therapy is generally regarded as one such unpleasant treatment. See Ivan Belknap, *Worry Warts*, in *BLUE JOLTS* 98 (Charles Steir ed., 1978); ROBERT M. VEATCH, *CASE STUDIES IN MEDICAL ETHICS* 309-10 (1977).

⁷⁰ For instance, some neuroleptic medications that are used to treat schizophrenia can cause tardive dyskinesia, a potentially fatal disease that attacks the nervous system. See Daniel E. Casey, *The Differential Diagnosis of Tardive Dyskinesia*, 291 *ACTA PSYCHIATRICA SCANDINAVICA SUPPLEMENTUM* 71, 71-73 (1981).

⁷¹ See Jean Hopfensperger, *Mental Patients Can Direct Treatment with a "Living Will"*, *MINNEAPOLIS STAR TRIB.*, Jan. 17, 1992, at 1B.

⁷² The "psychiatric will" was first proposed in Thomas S. Szasz, *The Psychiatric Will: A New Mechanism for Protecting Persons Against "Psychosis" and Psychiatry*, 37 *AM. PSYCHOLOGIST* 762 (1982).

⁷³ *Id.* at 766.

⁷⁴ See Hopfensperger, *supra* note 71.

petence.⁷⁵ In addition, by using guardianship statutes and powers of attorney, she was able to arrange for the care of her child, as well as for the orderly maintenance of her life's affairs.⁷⁶

2. *Disease-Motivated Refusal of Competently Requested Treatment*

The second group of patients desirous of advance treatment directives are those with illnesses, such as schizophrenia or manic depression, that can cause the patients to refuse offers of treatment. Once a relapse begins, such patients become uncooperative and often, as a result of the disease, refuse to accept any treatment.⁷⁷ Before they can receive medical care, patients generally must endure a lengthy incompetency hearing. If a patient is found incompetent, the court can issue a treatment order providing for forced medication, which may allow a return to lucidity.⁷⁸ Early treatment in such cases, however, could prevent a patient from experiencing a full relapse with all its symptoms, and could save the time, cost and suffering of a lengthy illness.⁷⁹

The costs of a full-blown mental illness requiring hospitalization can be extensive.⁸⁰ These costs are often borne by the state because many mental patients are committed to state-run facilities.⁸¹ In addition to the costs of care and treatment, a long mental illness decreases the patient's productivity, and often that of the patient's family as well.⁸² Finally, such mental illness involves great suffering on the part of the patient and his family.⁸³

To reduce the suffering and costs involved in a long illness, commentators have suggested using a "Ulysses contract."⁸⁴ The document adopts the Roman name of the Greek hero Odysseus who ordered his companions to bind him to his ship's mast and to ignore his pleas to be released as they sailed past the island of the Sirens.⁸⁵ The Ulysses contract is intended to allow a physician to ignore the

⁷⁵ See Hopfensperger, *supra* note 71.

⁷⁶ See Hopfensperger, *supra* note 71.

⁷⁷ See DSM-III-R, *supra* note 4, at 196.

⁷⁸ See MINN. STAT. § 253A.07 subd. 3 (1982).

⁷⁹ See Rosenson & Kasten, *supra* note 7, at 1 (discussing the impact of having to wait for medication).

⁸⁰ See *supra* note 8.

⁸¹ See *supra* note 8.

⁸² See Smith, *supra* note 9.

⁸³ See Smith, *supra* note 9.

⁸⁴ The origin of the term is unclear, but it was used as early as 1982. See Hastings Center, Case Study, *Can a Subject Consent to a "Ulysses Contract"?*, HASTINGS CENTER REP., Aug. 1982, at 26. A detailed proposal for a "voluntary commitment contract," very similar to the Ulysses contract, was made that same year. See also Howell, *supra* note 11, at 163.

⁸⁵ See *supra* note 10.

treatment refusals of an incompetent patient when the patient's illness is the source of the refusals.⁸⁶

Cast as an agreement between a patient and his or her physician,⁸⁷ this "contract" is very different from any advance directive that has been used or proposed in the past and raises difficult ethical and legal questions.⁸⁸ The greatest legal concern is that these contracts cannot be enforced in the absence of legislation specifically endorsing them.⁸⁹ The only useful recourse in the event of a subsequent treatment refusal would be specific performance—a remedy generally disfavored by the courts.⁹⁰ Additionally, existing treatment control documents cannot be adapted for use by patients with recurrent mental illnesses.⁹¹

Because it is statutorily supported, a Ulysses directive is different from a Ulysses contract and avoids the contract's problems. Like a Ulysses contract, the Ulysses directive gives instructions to the patient's physicians on how the patient is to be treated; permission to ignore subsequent incompetent treatment refusals, however, is a unique feature of the Ulysses directive. Although contract-based objections do not apply to the directive, other concerns remain and new problems arise.⁹²

One of the greatest dangers of Ulysses directives is the possibility that a patient with such a directive, who is in fact competent to refuse treatments, will be denied the ability to make a competent treatment refusal. This danger has due process ramifications and poses the greatest challenge to legislatures seeking to draft a Ulysses directive enabling statute.⁹³

Despite the intricacies involved in drafting such a statute, the benefits to the patient, his family, and the state in avoided costs and

⁸⁶ See Morton E. Winston & Sally M. Winston, Commentary to Case Study, *Can a Subject Consent to a "Ulysses Contract"?*, HASTINGS CENTER REP., Aug. 1982, at 26-27 [hereinafter Winston & Winston, *Consent to a "Ulysses Contract"*].

⁸⁷ The first suggested methods for the avoidance of the incompetent refusal of requested treatment were contracts for treatment between the patient and the physician. When the patient, as expected, refused treatment, the physician could sue in contract for specific performance. There were obvious problems with this sort of agreement, but they were seen as the only way to solve the Ulysses problem in the absence of a statute enabling Ulysses directives. See Dresser, *Ulysses and the Psychiatrists*, *supra* note 12, at part II.

⁸⁸ For discussions of the ethical concerns raised by Ulysses contracts see, *id.*; Winston & Winston, *Consent to a "Ulysses Contract"*, *supra* note 86, at 26; Paul Chodoff & Roger Peele, *The Psychiatric Will Of Dr. Szasz*, HASTINGS CENTER REP., Apr. 1983, at 11-12; Dresser, *Bound to Treatment*, *supra* note 12, at 15-16. For the legal implications of such a statute see discussion *infra* part II.B.

⁸⁹ See Dresser, *Ulysses and the Psychiatrists*, *supra* note 12, at part II.

⁹⁰ See JOHN D. CALAMARI & JOSEPH M. PERILLO, *CONTRACTS* § 16-1 (3d ed. 1987).

⁹¹ See discussion *supra* part I.A.2.a.

⁹² See discussion *infra* part II.B.

⁹³ See discussion *infra* part II.B.

suffering more than justify the effort. As yet, no state has passed a true enabling statute, but Minnesota has taken the first steps.

C. First Steps in Minnesota

In 1991, in order to address the special treatment decision problems of patients with mental illnesses, Minnesota became the first state⁹⁴ to enact a statute allowing citizens to draft directives for intrusive mental health treatments.⁹⁵ The statute, organized much

⁹⁴ The advance psychiatric directive statute is still unique to Minnesota.

⁹⁵ The relevant portions of the statute are:

Subd. 6b. **CONSENT FOR MENTAL HEALTH TREATMENT.** A competent person admitted or committed to a treatment facility may be subjected to intrusive mental health treatment only with the person's written informed consent. For purposes of this section, "intrusive mental health treatment" means electroshock therapy and neuroleptic medication and does not include treatment for mental retardation. An incompetent person who has prepared a directive under subdivision 6d regarding treatment with intrusive therapies must be treated in accordance with this section, except in cases of emergencies.

Subd. 6c. **ADMINISTRATION OF NEUROLEPTIC MEDICATIONS.** . . .

. . . .
(c) A neuroleptic medication may be administered to a patient who is not competent to consent to neuroleptic medications if the patient, when competent, prepared a declaration under subdivision 6d requesting the treatment or authorizing a proxy to request the treatment or if a court approves the administration of the neuroleptic medication.

. . . .
Subd. 6d. **ADULT MENTAL HEALTH TREATMENT.** (a) A competent adult may make a declaration of preferences or instructions regarding intrusive mental health treatment. These preferences or instructions may include, but are not limited to, consent to or refusal of these treatments.

(b) A declaration may designate a proxy to make decisions about intrusive mental health treatment. A proxy designated to make decisions about intrusive mental health treatments and who agrees to serve as a proxy may make decisions on behalf of a declarant consistent with any desires the declarant expresses in the declaration.

(c) The physician or provider must comply with [the declaration] to the fullest extent possible, consistent with reasonable medical practice, the availability of treatments requested, and applicable law. . . .

(d) If the declarant has been committed as a patient under this chapter, the physician or provider may subject a declarant to intrusive treatment in a manner contrary to the declarant's expressed wishes, only upon order of the committing court. If the declarant is not a committed patient under this chapter, the physician or provider may subject the declarant to intrusive treatment in a manner contrary to the declarant's expressed wishes, only if the declarant is committed as mentally ill or mentally ill and dangerous to the public and a court order authorizing the treatment has been issued.

(e) A declaration under this subdivision may be revoked in whole or in part at any time and in any manner by the declarant if the declarant is competent at the time of revocation. A revocation is effective when a competent declarant communicates the revocation to the attending physician or other provider.

like a living will enabling statute,⁹⁶ allows for consent to or refusal of treatments;⁹⁷ designation of a proxy to make decisions for the incompetent patient;⁹⁸ and revocation by a competent patient.⁹⁹ The statute requires a physician informed of the existence of an advance psychiatric directive to fulfill its demands to the greatest extent possible,¹⁰⁰ and protects from liability a physician who acts in good faith reliance on the validity of the directive.¹⁰¹

The statute also governs the use of neuroleptic medications,¹⁰² which can have serious side effects.¹⁰³ The statute explicitly allows neuroleptic treatment of a non-objecting, incompetent patient with an advance psychiatric directive authorizing the treatment.¹⁰⁴ A physician may treat such a patient without a court order.¹⁰⁵

II

MINNESOTA MENTAL HEALTH TREATMENT LAW

The Minnesota advance psychiatric directive statute allows patients to give advance consent to intrusive mental health treatments.¹⁰⁶ However, even when a patient makes an incompetent refusal, Minnesota courts will require the usual hearings for the forced administration of intrusive mental health treatments.¹⁰⁷ This section will examine the Ulysses directive's interaction with Minnesota law. It will also show that because most states' mental health laws are similar to Minnesota's, a Minnesota Ulysses directive enabling statute could serve as a model for other states. This would benefit patients with mental illnesses in other states who need the Ulysses directive for the same reasons Minnesotans do.¹⁰⁸ This part will first examine Minnesota's incompetency law and its treatment of patients with mental illness. It will then conclude that Minnesota's hostility towards excessive physician power will prevent the use of a Ulysses directive under the current statute.

⁹⁶ The Minnesota advance psychiatric directive statute is analyzed in greater detail *infra* part II.B.

⁹⁷ § 253B.03, subd. 6d(a).

⁹⁸ § 253B.03, subd. 6d(b).

⁹⁹ § 253B.03, subd. 6d(e).

¹⁰⁰ § 253B.03, subd. 6d(c)[4].

¹⁰¹ § 253B.03, subd. 6d(f).

¹⁰² § 253B.03, subd. 6c. Nowhere in the statute is "neuroleptic medication" defined. "Neuroleptics" are antipsychotic drugs that act, with one exception, by blocking the dopamine receptor. MERCK MANUAL OF DIAGNOSIS AND THERAPY 1635 (Robert Berkow et al. eds., 16th ed. 1992).

¹⁰³ Hastings Center, Case Study, *Consent to a "Ulysses Contract," supra* note 70, at 26.

¹⁰⁴ § 253B.03, subd. 6c(c). See discussion *infra* 151-53 and accompanying text.

¹⁰⁵ § 253B.03, subd. 6c(c).

¹⁰⁶ § 253B.03, subd. 6d(a).

¹⁰⁷ See discussion *infra* part II.B.

¹⁰⁸ See discussion *supra* part I.B.2.

A. Minnesota Incompetency Law

Minnesota's current law on the right of the mentally ill to refuse treatment has evolved through a long line of cases. Although this case law is more developed and extensive than that of other states,¹⁰⁹ the principles on which it relies and the conclusions it reaches are fairly uniform among the various jurisdictions.¹¹⁰

¹⁰⁹ The major Minnesota cases in this area are: *Price v. Sheppard*, 239 N.W.2d 905 (Minn. 1976); *Minnesota St. Bd. of Health v. City of Brainerd*, 241 N.W.2d 624 (Minn. 1976), appeal dismissed 429 U.S. 803 (1976); *In re Kinzer*, 375 N.W.2d 526 (Minn. Ct. App. 1985); *Jarvis v. Levine*, 403 N.W.2d 298 (Minn. Ct. App. 1987) *aff'd in part, and rev'd in part*, 418 N.W.2d 139 (Minn. 1988); *In re Jarvis*, 433 N.W.2d 120 (Minn. Ct. App. 1988); *In re Steen*, 437 N.W.2d 101 (Minn. Ct. App. 1989); *In re Lambert*, 437 N.W.2d 106 (Minn. Ct. App. 1989); *In re Schmidt*, 443 N.W.2d 824 (Minn. 1989); *In re Peterson*, 446 N.W.2d 669 (Minn. Ct. App. 1989); *In re Muntner*, 470 N.W.2d 717 (Minn. Ct. App. 1991); *In re Chonis*, 478 N.W.2d 199 (Minn. 1991); *In re Blilie*, 484 N.W.2d 34 (Minn. Ct. App. 1992), *aff'd*, 494 N.W.2d 877 (Minn. 1993). There are also several unreported cases applying established Minnesota law.

¹¹⁰ See *Barnes v. Dale*, 530 So. 2d 770 (Ala. 1988); *Anderson v. State*, 663 P.2d 570 (Ariz. Ct. App. 1982); *Riese v. Saint Mary's Hosp. & Medical Ctr.*, 271 Cal. Rptr. 199 (Ct. App. 1987); *Conservatorship of Waltz*, 227 Cal. Rptr. 436 (Ct. App. 1986); *Keyhea v. Rushen*, 223 Cal. Rptr. 746 (Ct. App. 1986); *Conservatorship of Fadley*, 205 Cal. Rptr. 572 (Cal. Ct. App. 1984); *Aden v. Younger*, 129 Cal. Rptr. 535 (Ct. App. 1976); *Goedecke v. State Dep't of Institutions*, 603 P.2d 123 (Colo. 1979); *Hopkins v. People*, 772 P.2d 624 (Colo. Ct. App. 1988); *People ex rel. M.K.M.*, 765 P.2d 1075 (Colo. Ct. App. 1988); *People ex rel. Medina*, 662 P.2d 184 (Colo. Ct. App. 1982), *aff'd* 705 P.2d 961 (Colo. 1985); *People ex rel. Freeman*, 636 P.2d 1334 (Colo. Ct. App. 1981); *In re Bryant*, 542 A.2d 1216 (D.C. 1988); *In re Boyd*, 403 A.2d 744 (D.C. 1979); *Meeker v. State*, 584 So. 2d 169 (Fla. Dist. Ct. App. 1991); *People v. Lang*, 545 N.E.2d 327 (Ill. Ct. App. 1989); *In re Orr*, 531 N.E.2d 64 (Ill. Ct. App. 1988); *In re Tarpley*, 581 N.E.2d 1251 (Ind. 1991); *In re M.P.*, 510 N.E.2d 645 (Ind. 1987); *Clites v. State*, 322 N.W.2d 917 (Iowa Ct. App. 1982); *Gundy v. Pauley*, 619 S.W.2d 730 (Ky. Ct. App. 1981); *In re Roe*, 583 N.E.2d 1282 (Mass. 1992); *In re Weedon*, 565 N.E.2d 432 (Mass 1991); *In re Linda*, 519 N.E.2d 1296 (Mass. 1988); *Rogers v. Commissioner of Dep't of Mental Health*, 458 N.E.2d 308 (Mass. 1983); *In re Roe*, 421 N.E.2d 40 (Mass. 1981); *Belger v. Arnot*, 183 N.E.2d 866 (Mass. 1962); *Stowers v. Wolodzko*, 191 N.W.2d 355 (Mich. 1971); *Kolocotronis v. Ritterbusch*, 667 S.W.2d 430 (Mo. Ct. App. 1984); *Reiser v. Prunty*, 727 P.2d 538 (Mont. 1986); *Opinion of Justices*, 465 A.2d 484 (N.H. 1983); *In re B.*, 383 A.2d 760 (N.J. Super. Ct. Law Div. 1977); *In re W.S.*, 377 A.2d 969 (N.J. Juvenile and Domestic Relations Ct. 1977); *In re Sanders*, 773 P.2d 1241 (N.M. Ct. App. 1989); *Rivers v. Katz*, 495 N.E.2d 337 (N.Y. 1986); *In re Mary Ann D.*, 578 N.Y.S.2d 622 (App. Div. 1992); *In re McConnell*, 538 N.Y.S.2d 101 (App. Div. 1989); *Eleanor R. v. South Oaks Hosp.*, 506 N.Y.S.2d 763 (App. Div. 1986); *In re Garrett*, 538 N.Y.S.2d 919 (Sup. Ct. 1989); *In re Lesser*, 544 N.Y.S.2d 902 (Sup. Ct. 1989); *Savastano v. Saribeyoglu*, 480 N.Y.S.2d 977 (Sup. Ct. 1984); *New York Health & Hosps. Corp. v. Stein*, 335 N.Y.S.2d 461 (Sup. Ct. 1972); *In re Willis*, 599 N.E.2d 745 (Ohio Ct. App. 1991); *Clark v. Ohio Dep't of Mental Health*, 573 N.E.2d 794 (Ohio Ct. Claims 1989); *In re K.K.B.*, 609 P.2d 747 (Okla. 1980); *In re L.R.*, 497 A.2d 753 (Vt. 1985); *In re Schuoler*, 723 P.2d 1103 (Wash. 1986); *In re G.S.*, 348 N.W.2d 181 (Wis. 1984); *State ex rel. Roberta A.S. v. Waukesha County Human Servs. Dep't*, 491 N.W.2d 114 (Wis. Ct. App. 1992); *In re K.S.*, 433 N.W.2d 291 (Wis. Ct. App. 1988); *K.N.K. v. Buhler*, 407 N.W.2d 281 (Wis. Ct. App. 1987); *State ex rel. Jones v. Gerhardstein*, 400 N.W.2d 1 (Wis. Ct. App. 1986), *aff'd* 416 N.W.2d 883 (Wis. 1987).

In 1976 the Minnesota Supreme Court decided its first major treatment decision case, *Price v. Sheppard*,¹¹¹ holding that "intrusive" treatments infringe on a committed patient's right to privacy and therefore cannot be administered over a patient's refusal without judicial approval.¹¹² The court balanced the state's interest in making treatment decisions for a patient who is incompetent against the individual's highly protected privacy interest.¹¹³ It held that any treatment approved by a court must be the least intrusive under the circumstances, as determined by examining the treatment's characteristics.¹¹⁴ The court further found that psychosurgery and electroconvulsive therapy are both sufficiently intrusive so as to require a hearing before a patient can be given such treatment against her will.¹¹⁵ However, the court explicitly declined to rule on whether neuroleptic medication is also an intrusive treatment.¹¹⁶

In the 1988 case of *Jarvis v. Levine*¹¹⁷ the Minnesota Supreme Court filled this gap by holding that neuroleptic medication is indeed an intrusive mental health treatment.¹¹⁸ The *Jarvis* court distinguished commitment to a mental institution from incompetence to consent to or refuse treatment; the former does not entail the latter.¹¹⁹ The court stated explicitly that, "a finding of legal incompetence is a prerequisite to involuntary medication with neuroleptics."¹²⁰ The court neglected, however, to define incompetence or explain how it is to be established.

Minnesota's legal standards on incompetence to consent to medical procedures derive in large part from Dr. James C. Beck's

¹¹¹ 239 N.W.2d 905 (Minn. 1976).

¹¹² *Id.*

¹¹³ *Id.* at 911.

¹¹⁴ Factors which should be considered are (1) the extent and duration of changes in behavior patterns and mental activity effected by the treatment, (2) the risks of adverse side effects, (3) the experimental nature of the treatment, (4) its acceptance by the medical community of [Minnesota], (5) the extent of intrusion into the patient's body and the pain connected with the treatment, and (6) the patient's ability to completely determine for himself whether the treatment is desirable.

Id. at 913.

¹¹⁵ There are three requirements for such a proceeding, known as a *Price* hearing. First, where the patient or the patient's guardian has refused treatment, the medical director of the state hospital where the patient is committed must petition the local probate court for an order authorizing treatment. Second, the court must appoint a guardian ad litem to represent the patient's interests. Finally, the court must hold an adversary proceeding to determine the necessity and reasonableness of the proposed treatment. *Id.*

¹¹⁶ *Id.*

¹¹⁷ 418 N.W.2d 139 (Minn. 1988).

¹¹⁸ *Id.* at 148.

¹¹⁹ *Id.*

¹²⁰ *Id.* at 148 n.7.

1987 article, *Right to Refuse Antipsychotic Medication: Psychiatric Assessment and Legal Decision-making*.¹²¹ Dr. Beck wrote:

Although there is a wide range of expert psychiatric opinion on how to define competency, two basic elements are present in most definitions: the capacity to assimilate relevant facts, and an appreciation or rational understanding of the person's situation as it relates to the facts. A clinical definition that combines these two elements states that a mentally disordered person is competent to refuse to take antipsychotic medication if he or she is aware of having a mental disorder; has sufficient knowledge about medication and mental disorder; and does not base the refusal on delusional beliefs. A voluntary decision by a person who has this awareness and knowledge is a competent or legally valid decision.¹²²

A competent refusal of antipsychotic medication requires that the patient understand the reasons for the physician's prescription, including the physician's determination that the patient has a mental disorder.¹²³ However, the patient may disagree with the physician's assessment of the expected benefits and possible risks, and so competently refuse the treatment.¹²⁴

The Minnesota courts have adopted Beck's three-part analysis—awareness of disease, knowledge of treatments, and rationality in thought processes—in several decisions. The Minnesota Supreme Court in *Jarvis v. Levine*,¹²⁵ although failing to define "incompetence," cited Beck as a source of factors to consider in determining competence to refuse treatment.¹²⁶ The court of appeals' 1989 decision, *In re Lambert*,¹²⁷ held that a patient who did not meet the three Beck criteria was incompetent to refuse or accept treat-

¹²¹ James C. Beck, *Right to Refuse Antipsychotic Medication: Psychiatric Assessment and Legal Decision-making*, 11 MENTAL & PHYSICAL DISABILITY L. REP. 368 (1987).

¹²² *Id.* at 369 (footnotes omitted).

¹²³ *Id.*

¹²⁴ *Id.* ("Awareness, not agreement, is required for competence."). When a patient is suspected of making treatment refusals on the basis of delusions, it is important to make sure that she is in fact deluded. As Beck wrote, when a patient denies mental illness she might be deluded, or she might be correct. In such a case one can check the patient's symptoms against those listed in the American Psychiatric Association's *Diagnostic and Statistical Manual*. DSM-III-R, *supra* note 4. As a patient's reasons for treatment refusal become less clearly delusional, one must spend more time determining exactly what the patient's reasoning is. Beck, *supra* note 121, at 370.

This distinction between disagreement and delusional rejection of treatment prevails in other states as well. See *San Diego Dep't of Social Serv. v. Waltz*, 227 Cal. Rptr. 436, 443 (Ct. App. 1986) ("[T]he evidence indicates a disagreement between Waltz . . . and his physician This disagreement does not show Waltz' inability to give informed consent.").

¹²⁵ 418 N.W.2d 139 (1988).

¹²⁶ *Id.* at 148 n.7.

¹²⁷ 437 N.W.2d 106 (Minn. Ct. App. 1989).

ment with neuroleptics.¹²⁸ In another 1989 decision, *In re Peterson*,¹²⁹ the court of appeals also applied the Beck analysis to find a patient incompetent. In addition, the court explicitly stated that it would find incompetence in future cases if a patient failed to meet any of the three Beck criteria.¹³⁰

In 1988, the Minnesota Legislature encoded the framework of the *Jarvis* and *Price* competency hearing requirements in section 253B.03, subdivision 6a,¹³¹ which was later amended to include the psychiatric will provisions.¹³² The Minnesota Supreme Court rejected a constitutional challenge to the 1988 statute in *In re Schmidt*,¹³³ holding that the statute adequately embodied the protections developed in *Price* and *Jarvis*.¹³⁴ Specifically, the court determined that there was no facial violation of the Minnesota Constitution's guarantee of a right to privacy,¹³⁵ nor did the statute deprive the patient of any due process rights of notice, hearing or counsel.¹³⁶

In the absence of a patient's advance directive, Minnesota law requires that three conditions be met before a patient may be treated involuntarily with neuroleptics. First, the patient must have been committed as mentally ill, or mentally ill and dangerous;¹³⁷ second, the patient must be incompetent to consent;¹³⁸ and third, either (a) the patient's physicians must have obtained a court order

¹²⁸ *Id.* at 108.

¹²⁹ 446 N.W.2d 669 (Minn. Ct. App. 1989).

¹³⁰ *Id.* at 673. "The Beck criteria require a finding of all three in favor of the patient for competency to be found. Those advocating the use of involuntary neuroleptics need not disprove all three in order to prevail." *Id.*

¹³¹ Act of Apr. 28, 1988, ch. 689, art. 2, § 119, 1988 Minn. Laws 1279, 1362-63 (codified at MINN. STAT. § 253B.03, subd. 6 (Supp. 1993)).

¹³² Act of May 22, 1991, ch. 148, § 2, 1991 Minn. Laws 308, 310-11 (codified as amended at MINN. STAT. ANN. § 253B.03, subd. 6(c) (West Supp. 1993)).

¹³³ 443 N.W.2d 824 (Minn. 1989).

¹³⁴ *Id.* at 828. The challenges were specifically leveled at MINN. STAT. § 253B.03, subd. 6a(c)(1) (Supp. 1993). This section allows neuroleptic medication without a hearing when the patient does not consent if two other conditions are met: a guardian ad litem gives consent, and a multidisciplinary treatment review panel gives written approval. The court determined that when a patient is unable to express refusal, the guardian ad litem and the treatment review panel provide sufficient protection for the rights of the patient. *Id.* at 828.

¹³⁵ 443 N.W.2d at 827.

¹³⁶ *Id.* at 829-30.

¹³⁷ The Minnesota courts have not been confronted with any requests for an order to treat a non-committed patient with neuroleptics, psychosurgery or electroconvulsive therapy. Section 253B.03, subdivision 6c governs non-consensual treatment with neuroleptics of committed patients only. The standard for incompetence to consent to an intrusive treatment, however, is higher than that required for commitment as mentally ill. In ordinary non-consenting treatment cases, therefore, the requirement of commitment has little effect.

¹³⁸ The application of § 253B.03, subdivision 6c(d) is premised on the patient's lack of competence.

for the treatment,¹³⁹ or (b) the patient must have not objected to the treatment,¹⁴⁰ and both the patient's guardian ad litem¹⁴¹ and a treatment review panel must have approved the treatment.¹⁴² So far, this system has worked well to protect the rights of the mentally ill. As a result of physician respect for patient rights under this protective regime, Minnesota's courts have rejected very few physician requests for treatment orders.¹⁴³

The protections afforded patients with mental illnesses in Minnesota are based on principles that inform the analogous law of most other states.¹⁴⁴ These principles are threefold: 1) that there is a general right of patients with mental illnesses to refuse treatment, 2) that this right may be infringed upon only after a specific showing of incompetence to consent to the treatment, and 3) that incompetence will be determined based on criteria that resemble those outlined by Dr. Beck.¹⁴⁵

Many states find that the general right of a patient with a mental illness to reject treatment is based on a right of privacy found either in the federal or state constitution.¹⁴⁶ Regardless of the source of this right, many states agree that the patient's refusal of treatment cannot be overridden without an express determination of incompetency; involuntary commitment to a mental institution is not enough.¹⁴⁷

In determining whether a patient is competent to make treatment decisions, most courts employ some variation of Minnesota's

139 § 253B.03, subd. 6c(c) (Supp. 1993).

140 § 253B.03, subd. 6c(d)(1) (Supp. 1993).

141 § 253B.03, subd. 6c(d)(2) (Supp. 1993).

142 § 253B.03, subd. 6c(d)(3) (Supp. 1993).

143 See *supra* note 109.

144 See *infra* notes 146-48.

145 See *supra* notes 121-130 for a discussion of these three principles in Minnesota.

146 Minnesota bases such rights on its state constitution. *Jarvis v. Levine*, 418 N.W.2d 139, 148 (Minn. 1988). Other states vary, with some simply finding the right in common law. *Aden v. Younger*, 129 Cal.Rptr. 535 (Cal. Ct. App. 1976) (federal constitution); *Goedeker v. Colorado* 603 P.2d 123, 125 (Colo. 1979) (common law); *Opinion of the Justices*, Request of the Senate No. 83-239, 465 A.2d 484 (N.H. 1983) (state constitution); *Rivers v. Katz*, 495 N.E.2d 337, 341 (N.Y. 1986) (state constitution due process clause).

147 For a discussion of this rule in Minnesota, see *supra* discussion accompanying notes 119-20. For this rule in other states see *inter alia*: *In re Weedon*, 565 N.E.2d 432, 435 (Mass. 1991) ("[A] judicial finding of incompetence is a necessary precondition to any substituted judgment treatment order . . ."); *Rogers v. Commissioner of Dept. of Mental Health*, 458 N.E.2d 308, 314 (Mass. 1983) ("[A] mental patient has the right to make treatment decisions and does not lose that right until the patient is adjudicated incompetent by a judge through incompetence proceedings."); *Rivers v. Katz*, 495 N.E.2d 337 (N.Y. 1986); *Eleanor R. v. South Oaks Hosp.*, 506 N.Y.S.2d 763, 767 (N.Y. App. Div. 1986) ("Whether or not an involuntarily-committed mentally-ill patient has the capacity to make a reasonable decision with respect to a particular treatment is clearly a question of fact for a hearing court.").

Beck criteria.¹⁴⁸ They generally require that the patient be shown to have a mental illness that interferes substantially with the patient's decision-making process.¹⁴⁹ Such states find that a patient's denial of a proven disease is evidence that such disease has undermined the patient's decision-making powers.¹⁵⁰

The general protections provided by any state to patients with mental illnesses will determine the contours of that state's Ulysses enabling statute. The statute must fit into the established system for determining whether a patient is competent to consent to treatment and yet provide new treatment control choices. The law regarding treatment of patients with mental illnesses is fairly uniform among the states. Therefore, examining how a Ulysses enabling statute in one state interacts with general mental health law can provide useful lessons to the legislatures of other states.

B. Ulysses in Minnesota?—Penelope Still Waiting

1. *Refusal or Revocation?*

When a patient with a mental illness has executed a Ulysses directive pursuant to the Minnesota Statute, and is incompetent but does not refuse an invasive treatment, or is unable to communicate consent or refusal, the patient will be able to receive the treatment with little trouble. If the proposed treatment is a neuroleptic medication, section 253B.03, subdivision 6c(c)¹⁵¹ allows the physician to

¹⁴⁸ California, for example, states that:

Judicial determination of the specific competency to consent to drug treatment should focus primarily upon three factors: (a) whether the patient is aware of his or her situation . . . (b) whether the patient is able to understand the benefits and the risks of, as well as the alternatives to, the proposed intervention . . . and (c) whether the patient is able to understand and to knowingly and intelligently evaluate the information required to be given

Riese v. Saint Mary's Hosp. & Medical Ctr., 271 Cal. Rptr. 199, 211 (Cal. Ct. App. 1987). See Goedecke v. Colorado, 603 P.2d 123, 125 (Colo. 1979) (a patient will be found incompetent to consent to or refuse treatment if the patient's mental illness has so impaired his judgment that he is "incapable of participating in decisions affecting his health."); *In re Bryant*, 542 A.2d 1216 (D.C. Ct. App. 1988) (finding a patient incompetent because of her delusional beliefs that she was God, and her denial of mental illness); *In re Roe*, 583 N.E.2d 1282, 1286 (Mass. 1992) (ward determined incompetent to reject treatment because he "denies that he is mentally ill. . . . [He] understands the risks attendant on taking Stelazine, but he clearly does not appreciate the risks associated with refusing it.").

¹⁴⁹ See *supra* note 110.

¹⁵⁰ See *supra* note 110.

¹⁵¹ "A neuroleptic medication may be administered to a patient who is not competent to consent to neuroleptic medications if the patient, when competent, prepared a declaration under subdivision 6d requesting the treatment or authorizing a proxy to request the treatment" § 253B.03, subd. 6c(c) (Supp. 1993).

administer the treatment without court approval.¹⁵² If the proposed treatment is electroshock therapy, subdivision 6d(c)[4-5]¹⁵³ allows the same.

In a true Ulysses situation, however, the patient refuses the treatment, as was his expectation while competent. A well drafted Ulysses directive anticipates two kinds of refusal problems: a simple refusal of the treatment, and an attempt to revoke the Ulysses directive itself.¹⁵⁴ An advance psychiatric directive statute will be ineffective unless it can adequately resolve both types of treatment refusal problems. If one type of refusal destroys the effect of the Ulysses directive, the competent patient will not be able to rely on the directive to enact his competent wishes.

To be fully effective, the statute must solve such treatment refusal problems without resort to the courts. Because one reason for drafting a Ulysses directive is to avoid the delay inherent in obtaining a treatment order, a Ulysses enabling statute that regularly requires judicial intervention will give the Ulysses patient no advantage over reliance on the traditional process for determining incompetency.

Although the statute does not require it, there is little reason for Minnesota courts to treat the two refusal problems—rejection of treatment and revocation of the directive—differently. In either situation, the question reduces to one of whether the patient is competent to consent to the treatment. The Minnesota advance psychiatric directive statute anticipates the problem of treatment refusal. Paragraph (d) of subdivision 6c requires that the treatment refusal of one who has executed a Ulysses directive be a competent refusal.¹⁵⁵ It further allows for the administration of neuroleptics to a patient who is incompetent if that patient has executed a Ulysses

¹⁵² Where the patient makes no indication of refusal or is unable to consent or refuse for reasons of the mental illness, the predicate of subdivision 6c(c), that the patient is not competent to consent, is satisfied.

¹⁵³ The physician or provider must comply with [the declaration] to the fullest extent possible, consistent with reasonable medical practice, the availability of treatments requested, and applicable law. The physician or provider shall continue to obtain the declarant's informed consent to all intrusive mental health treatment decisions if the declarant is capable of informed consent.

§ 253B.03, subd. 6d(c)[4-5] (Supp. 1993).

¹⁵⁴ If the statute is unduly permissive, then refusal of treatment reduces to revocation of the directive. Some living will statutes allow revocation by any act or statement not consistent with an intention to keep the living will in force. A refusal of a treatment withdrawal under such a living will is an inconsistent act canceling the living will. A successful Ulysses directive cannot be so permissive in the options it allows for revocation.

¹⁵⁵ § 253B.03, subd. 6c(b-c) (Supp. 1993).

directive.¹⁵⁶ Unlike paragraph (d), paragraph (c)¹⁵⁷ does not explain what to do if the patient refuses the treatment. This absence, read together with the next paragraph's explicit mention of a treatment refusal, suggests that paragraph (c) would allow the forced treatment of an incompetent, refusing patient who has executed a Ulysses directive.

When the problem is one of attempted revocation, the question becomes what standard of competence the patient must meet to make the revocation.¹⁵⁸ To draft a treatment directive, the patient must be competent to consent to or reject treatments.¹⁵⁹ Because the directive contains treatment consents or refusals, the revocation of such a directive amounts to a treatment refusal or acceptance. The standard for revoking a treatment directive should therefore be the same as that required for drafting one, namely competence to consent to or refuse treatments. This is the same standard that must be met in the case of simple treatment refusal.

A different subsection of the statute governs electroconvulsive therapy,¹⁶⁰ but the analysis is the same. The statute requires the physician or provider to "obtain the declarant's informed consent to all intrusive mental health treatment decisions if the declarant is capable of informed consent."¹⁶¹ Electroshock therapy is specifically included in the definition of "intrusive mental health treatment,"¹⁶² so again the question reduces to one of competence to consent to the treatment.

The inquiry does not end by asking whether the patient is competent to consent to a treatment. If the patient is found incompetent to consent to the treatment, the court must establish that the treatment is reasonable and appropriate for the patient.¹⁶³ A Ulysses directive enabling statute must be able to account for this step of the process leading to treatment.

¹⁵⁶ *Id.*

¹⁵⁷ See *supra* notes 137-42 and accompanying text.

¹⁵⁸ "A declaration under this subdivision may be revoked in whole or in part at any time and in any manner by the declarant if the declarant is competent at the time of revocation." § 253B.03, subd. 6d(e) (Supp. 1993). The statute does not specify the applicable standard of competence.

¹⁵⁹ § 253B.03, subd. 6d(a) (Supp. 1993).

¹⁶⁰ The administration of neuroleptics is governed specifically by § 253B.03 subdivision 6c, and generally by subdivision 6d. Electroshock therapy is controlled by subdivision 6d.

¹⁶¹ § 253B.03, subd. 6d(c)[5] (Supp. 1993).

¹⁶² § 253B.03, subd. 6b (Supp. 1993).

¹⁶³ See discussion *infra* part II.B.2.

2. *Price/Jarvis Reasonableness Hearing*

In *Price v. Sheppard*,¹⁶⁴ the Supreme Court of Minnesota ruled that the forcible administration of intrusive mental health treatments to a committed incompetent patient requires a court order.¹⁶⁵ In making such a determination, a court must hold an adversary proceeding to "determine the necessity and reasonableness of the prescribed treatment."¹⁶⁶ The *Price* court listed six factors for a court to consider in making the reasonableness and necessity determination.¹⁶⁷ The last factor is "the patient's ability to competently determine for himself whether the treatment is desirable."¹⁶⁸ This factor is essentially a determination of competency to consent to the treatment. Presumably, where the court finds that the patient is entirely able to decide for herself whether to accept the treatment, it will find coerced treatment unreasonable and unnecessary.¹⁶⁹

The Minnesota Supreme Court in *Jarvis v. Levine*¹⁷⁰ made clear that the hearings have two purposes: (1) to determine whether the patient is indeed unable to consent to treatment,¹⁷¹ and (2) to determine the reasonableness and necessity of the proposed treatment.¹⁷² Incompetence to consent to the treatment is the threshold for the assessment of the treatment.¹⁷³

The patient's drafting of a Ulysses directive obviates the second part of the *Price/Jarvis* hearing. While drafting her Ulysses directive, the patient will have the same information available to her as a court holding a *Price/Jarvis* hearing. If such a patient is competent, as she must be to draft a Ulysses directive,¹⁷⁴ then she is just as capable as the courts of weighing the first five factors that the *Price* court recommended for determining the necessity and reasonableness of a proposed treatment.¹⁷⁵ She can list conditions under which her

¹⁶⁴ 239 N.W.2d 905 (Minn. 1976).

¹⁶⁵ *Id.* at 913.

¹⁶⁶ *Id.* Most other states also require some sort of hearing to determine the advisability of the proposed treatment. See *People v. Medina*, 705 P.2d 961 (Colo. 1985); *supra* note 110. This is sometimes referred to as "substituted judgment." See *In re Bryant*, 542 A.2d 1216 (D.C. 1988).

¹⁶⁷ See *supra* note 112.

¹⁶⁸ 239 N.W.2d at 913.

¹⁶⁹ The premise of the hearing is, after all, that "[t]he state's interest in assuming the decision is in acting as *parens patriae*, fulfilling its duty to protect the well-being of its citizens who are incapable of so acting for themselves." (emphasis added). *Id.* at 911.

¹⁷⁰ 418 N.W.2d 139 (Minn. 1988).

¹⁷¹ *Id.* at 148 n.7.

¹⁷² *Id.* at 148.

¹⁷³ *Id.* at 148 n.7.

¹⁷⁴ 253B.03, subdivision 6d(a) states: "A competent adult may make a declaration. . . ." (emphasis added).

¹⁷⁵ See *supra* note 114.

physician should make changes to the proposed treatment, and she can put limits and conditions on dosages or types of medications.¹⁷⁶

One extra purpose that the *Price/Jarvis* hearing might serve is to verify that the patient is actually suffering from the condition for which she was planning. Courts have usually made such determinations by referring to the descriptions of illnesses listed in the American Psychiatric Association's *Diagnostic and Statistical Manual, Third Edition (DSM-III)*.¹⁷⁷ Absent bad faith on the part of the treating physician, the determination of illness is straight-forward and uncontroversial.¹⁷⁸ If a physician thought of using a Ulysses directive to treat a patient in inappropriate situations, the threat of an adversary hearing to establish the patient's illness might give the physician pause. It is not clear whether such a hearing would stop a very determined physician.

The illness verification element of the *Price/Jarvis* hearing probably affords no more protection than the Minnesota Statute already provides. The statute requires the physician to "comply with [the directive] to the fullest extent possible, consistent with reasonable medical practice . . . and applicable law."¹⁷⁹ A physician applying the criteria of *DSM-III-R*¹⁸⁰ in good faith will go through the same steps, and thus reach the same result, as a court. If the physician reaches a different conclusion, she could be liable for treating the patient in a manner at variance with the provisions of the patient's Ulysses directive or for malpractice in misapplying *DSM-III-R*.¹⁸¹

3. Competence to Consent

The determination of competence to consent to treatment is a court's most important function in treatment decision cases, and the

176 § 253B.03, subd. 6d(a) (Supp. 1993).

177 See Beck, *supra* note 121, at 370; AMERICAN PSYCHIATRIC ASSOCIATION, *DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS: DSM-III* (3d ed. 1978). In 1987 the American Psychiatric Association came out with revised version of the third edition—*DSM-III-R*—and it is now at work on *DSM-IV*.

178 "DSM-III and DSM-III-R provide specific diagnostic criteria as guides for making each diagnosis since such criteria enhance interjudge diagnostic reliability." *DSM-III-R*, *supra* note 4, at xxiv.

179 § 253B.03, subd. 6d(c)[4] (Supp. 1993).

180 *DSM-III-R* is currently the appropriate manual for use.

181 § 253B.03, subd. 6d(c)[4] (Supp. 1993). The statute requires treatment in accordance with the Ulysses directive, but does not provide specifically for punishment. If the physician has applied a treatment not approved by the patient in her directive, a remedy will probably exist under a theory of assault and battery. If the physician varies from the directive by not providing treatment, and has not complied with the subdivision 6d(d)[2] notification requirements, the patient will probably have a malpractice case against the physician. This might be premised on either a per se violation of subdivision 6d(d)[2], or on a breach of assumed duty to treat. By failing to voice an intention not to treat when presented with the directive, the physician implicitly agrees to act in accordance with the directive.

one that courts are least likely to surrender.¹⁸² In Ulysses situations, this determination is central to the effectiveness of the directive. It also highlights the dangers of misapplication of a Ulysses directive.

a. *The Ulysses Directive's Scylla and Charybdis*

There are two dangers in making a determination of a patient's ability or inability to consent: refusing consent to one truly capable of consent, and giving the power of consent to one who is not competent to exercise that power. The first danger conflicts with fundamental interests of liberty, privacy, and autonomy and raises serious due process and equal protection concerns.¹⁸³ If a statute is poorly drafted, it might enable some patients with mental illnesses to plan for and control their illnesses, while it subjects others to truly unwanted treatment. Because due process concerns require that a statute affecting a fundamental interest be narrowly tailored to its legitimate end,¹⁸⁴ and because the ability to refuse intrusive treatment is a fundamental individual right,¹⁸⁵ the constitutionality of a Ulysses statute may depend on how well it avoids this first danger.¹⁸⁶

The second problem is the one that the Ulysses directive is specifically designed to avoid.¹⁸⁷ The enabling statute must not be so

¹⁸² It would be both unreasonable and unnecessary for the courts to become involved in every post-commitment treatment decision; however, it is equally clear that the courts cannot abdicate *all* responsibility for protecting a committed person's fundamental rights merely because some degree of medical judgment is implicated. *When medical judgments collide with a patient's fundamental rights . . . it is the courts, not the doctors, who possess the necessary expertise.*

Jarvis v. Levine, 418 N.W.2d 139, 147-148 (Minn. 1988) (emphasis added). Other courts have made similar statements:

The determination by a physician that an individual is mentally incompetent to refuse drug treatment cannot be exempted from judicial evaluation on the ground that the medical determination rests upon an unimpeachable scientific foundation. . . . [F]orcible administration of powerful mind-altering drugs also involves moral and ethical considerations not solely within the purview of the medical profession, and must be measured by the social consensus reflected in our laws. Exemption of these decisions from such external evaluation would invest physicians with a degree of power over others . . . [at odds] with the great value our society places on the autonomy of the individual.

Riese v. Saint Mary's Hosp. & Medical Ctr., 271 Cal. Rptr. 199, 212-13 (Cal. Ct. App. 1987).

¹⁸³ See Dresser, *Ulysses and the Psychiatrists*, *supra* note 12, at §§ III.A., B., D. (discussing constitutional concerns with voluntary commitment contracts).

¹⁸⁴ Roe v. Wade, 410 U.S. 113, 155 (1972).

¹⁸⁵ But see Minnesota State Bd. of Health v. Brainard, 241 N.W.2d 624 (Minn. 1976) (upholding fluoridation of local water supply over individual interest in not receiving fluoridation treatment).

¹⁸⁶ See Dresser, *Ulysses and the Psychiatrists*, *supra* note 12, at part III.D.

¹⁸⁷ See Joseph A. Rogers & Benedict Centitanti, *Beyond "Self-Paternalism": Response to Rosenson and Kasten*, 17 SCHIZOPHRENIA BULL. 9, 10 (1991).

weak that it allows patients who have executed Ulysses directives either to reject treatments, or to postpone the application of a treatment until after a hearing. Otherwise, the Ulysses directive will be of limited value.

The ideal is to correctly designate every person as competent or incompetent. Where this is not attainable, however, constitutional jurisprudence suggests that making the second of the two errors is preferable to making the first.¹⁸⁸ Therefore, where a directive enabling statute cannot be precise, it should be too weak rather than too strong.

The Minnesota courts' model for determining ability to consent to treatment¹⁸⁹ specifies those abilities necessary for a competent exercise of treatment choice. The exercise of discretion comes in applying the criteria to a case. When the patient denies having an illness, for example, there are two possibilities: (1) the patient is making an honest, true statement, or (2) the patient is deluded. In such circumstances the courts decide by referring to *DSM-III-R*.¹⁹⁰ Where there is strong evidence that the patient has an illness, but the patient denies it, a court will find the patient incompetent to make treatment decisions.¹⁹¹ If the court suspects that the patient is basing her treatment refusal on delusional beliefs, the court may have to question the patient personally in order to assess the patient's ability to reason.¹⁹²

The problem with Ulysses directives is that they rely for their effectiveness on a quick determination of illness and competency.¹⁹³ To make Ulysses directives work, the courts must be willing either to provide very quick access for competency assessments, or to delegate the competency assessment function. Minnesota law allows for commitment hearings within fourteen days of a request for one, with a potential thirty-one day extension on a showing of good cause.¹⁹⁴ For a patient with a degenerating mental illness, however, having to wait two weeks before beginning treatment can be a significant hardship. Rather than being able to receive treatment on an outpatient basis, the patient may experience a full-blown relapse re-

188 The decision requires the balancing of fundamental personal interests—privacy, autonomy, self-determination—with the state *parens patriae* interest. The state therefore has the burden of establishing its interest via a finding of competence, before it can consider invading the individual's fundamental interests.

189 See *supra* text accompanying notes 121-30.

190 Beck, *supra* note 121, at 370 (stating that *DSM-III* is used). Courts now use the later version, *DSM-III-R*.

191 Beck, *supra* note 121, at 370.

192 Beck, *supra* note 121, at 370.

193 See discussion *supra* part I.B.2. explaining the need for Ulysses directives.

194 MINN. STAT. § 253A.07, subd. 8 (1982).

quiring hospitalization.¹⁹⁵ The questions then become: how well can the results of extra-judicial competency assessments replicate traditional assessments, and how well can the patient's constitutional rights be protected outside of the courtroom?

b. *Replicability*

The first Beck criterion for assessing competency—that the patient be aware of her illness—is relatively straightforward and easy to apply.¹⁹⁶ *DSM-III-R* was designed to provide objective and consistent diagnoses of illnesses and so lends itself to the out-of-court application of a Ulysses directive.¹⁹⁷

The second Beck criterion, that the patient be able to understand and assess the treatment options,¹⁹⁸ can also be objectively analyzed. A group at Johns Hopkins University has proposed a competency assessment test that fulfills this purpose.¹⁹⁹ The fifteen-minute long test is given orally and can be adjusted for the reading level of the patient.²⁰⁰ The administrator of the test reads the patient a short passage about competency and then poses a series of questions about the passage.²⁰¹ The answers are used to determine understanding and analytical ability.²⁰² Because this method is objective, it does not allow as much flexibility as that enjoyed by a judge questioning a patient. Where the patient scores very close to the threshold for competency, it might be difficult to say conclusively whether the patient is in fact competent. In these circumstances, the physician can either supplement the exam with a longer, more extensive test, or send the patient to a hearing. This decision can be made simply on the basis of the patient's initial score, thereby eliminating worries about physician discretion.

The third criterion is the most difficult to analyze, as Beck himself points out.²⁰³ The patient's basis for refusal of treatment may be part delusional and part rational. The person who determines competency must therefore question the patient to the extent necessary to determine the patient's true reasons for refusing treatment,

195 Rosenson & Kasten, *supra* note 7, at 3.

196 See discussion *supra* accompanying notes 121-30.

197 See discussion *supra* accompanying notes 177-78.

198 See *supra* text accompanying note 122.

199 Jeffrey S. Janofsky et al., *The Hopkins Competency Assessment Test: A Brief Method for Evaluating Patients' Capacity to Give Informed Consent*, 43 J. HOSP. & COMMUNITY PSYCHIATRY 132 (1992).

200 "Versions of the essay at the 13th-grade, eighth-grade, and sixth-grade reading levels were prepared." *Id.* at 132.

201 *Id.*

202 *Id.*

203 Beck, *supra* note 121, at 370.

and must examine the rationality of those reasons.²⁰⁴ At this point, a physician's bad faith, inexperience or lack of thoroughness will be most able to affect the outcome of the competency assessment.

If a patient fails to meet any one of these three Beck criteria, she will be deemed incompetent.²⁰⁵ In a large number of the diseases for which patients would create Ulysses directives, the patient denies illness. For cases in which the denial of illness is one, or the only, failed criteria, the result of the competency assessment is likely to be identical to that of a court. The same holds true if the patient fails to meet only the second criterion. When the delusional belief criterion comes into play, however, physicians might be inclined to look harder for a failure in another area. Courts may, therefore, be loathe to delegate competency assessment. Such a partial delegation may not adequately protect the patient.

c. *Protecting Patients' Rights*

The Minnesota courts have found that due process rights under the Minnesota Constitution are stronger than analogous federal protections; therefore, courts decide such cases using the Minnesota Constitution.²⁰⁶ Minnesota Supreme Court Justice Yetka was referring to rights afforded by the Minnesota Constitution when he wrote in *Jarvis v. Levine*²⁰⁷ that "[w]hen medical judgments collide with a patient's fundamental rights . . . it is the courts, not the doctors, who possess the necessary expertise."²⁰⁸

The Minnesota courts, like the courts of most states,²⁰⁹ regard the right to refuse treatment very highly,²¹⁰ and are unlikely to allow an infringement of this right without a strong showing. The state courts are also careful to limit power given to physicians in treatment decision cases.²¹¹

The federal courts are not as reluctant to allow physicians broad treatment power. In 1982 the United States Supreme Court decided *Youngberg v. Romeo*,²¹² holding that, in determining whether

²⁰⁴ Beck, *supra* note 121, at 370.

²⁰⁵ *In re Peterson*, 446 N.W.2d 669, 673 (Minn. Ct. App. 1989).

²⁰⁶ See *In re Schmidt* 443 N.W.2d 824, 827 (Minn. 1989). Other state courts have also construed their constitutions as providing broader protections than the Federal Constitution. See, e.g., *Rogers v. Commissioner of the Dep't of Mental Health*, 458 N.E.2d 308 (Mass. 1983).

²⁰⁷ 418 N.W.2d 139 (Minn. 1988).

²⁰⁸ *Id.* at 147-48.

²⁰⁹ See *supra* note 146.

²¹⁰ "To deny mentally ill individuals the opportunity to exercise [the right to refuse treatment] is to deprive them of basic human dignity by denying their personal autonomy." *Jarvis v. Levine*, 418 N.W.2d 139, 148 (Minn. 1988).

²¹¹ *Id.* at 148. See *supra* note 110.

²¹² 457 U.S. 307 (1982).

an institution had met its obligations to patients with developmental disabilities, "courts must show deference to the judgment exercised by a qualified professional."²¹³

The Minnesota Court of Appeals adopted *Youngberg's* standard in *Jarvis v. Levine*,²¹⁴ concluding that where the decision to invade a patient's liberty interests is made in the exercise of professional judgment, due process requirements are satisfied.²¹⁵ The court of appeals also cited decisions from other states applying the "professional judgment" standard.²¹⁶

The Minnesota Supreme Court rejected this adoption of the professional judgment standard and distinguished *Youngberg*. The court held that the professional judgment standard does not apply under Minnesota law to intrusive mental health treatments administered against a patient's wishes.²¹⁷ The court cited changing social values regarding the nature of the physician-patient relationship, as well as the crimes committed by Nazi physicians during World War II, as reasons for being cautious in allocating decision making power to physicians.²¹⁸ It also rejected the lower court's contention that Minnesota recognized "[a] presumption of incompetency to make psychiatric treatment decisions when commitment is premised on a finding of mental illness. . . ."²¹⁹

The coldness with which the Minnesota judiciary regards the idea of treatment decision power in the hands of physicians will be the downfall of any attempt at a Ulysses directive under the current Minnesota advance psychiatric directive statute. There are no statutory provisions for either an accelerated competency hearing or for the delegation of such a function to the declarant's physicians. The

²¹³ *Id.* at 322.

²¹⁴ 403 N.W.2d 298 (Minn. Ct. App. 1987), *aff'd in part, rev'd in part*, by 418 N.W.2d 139 (Minn. 1988).

²¹⁵ *Id.* The Minnesota Court of Appeals also cited the Supreme Court's remand of *Rennie v. Klein*, 458 U.S. 1119 (1982) as support for its position.

²¹⁶ 403 N.W.2d at 309.

²¹⁷ 418 N.W.2d at 147. Without specifically rejecting *Youngberg*, most other state courts also impose a higher standard in treatment decision cases than the professional judgment standard. See *supra* note 110.

²¹⁸ "The public has been unwilling, quite properly, to allow professionals such as lawyers, doctors, dentists and others a completely free hand in handling either a client, customer or patient's case." 418 N.W.2d at 148. "[W]e recall that mental patients in the past have been used as tools for experimentation and new techniques. Many of the atrocities committed in Nazi Germany were allegedly carried out under the guise of 'improving' medical science."

²¹⁹ 403 N.W.2d at 307. The Minnesota Supreme Court rejected this contention. 418 N.W.2d at 147 ("Commitment to an institution does not deprive an individual of all legal rights").

Minnesota Courts are unlikely to allow any approximation of these functions without express legislative approval.²²⁰

III

CHANGING THE LAW IN ULYSSES' FAVOR

To accommodate fully the needs of a patient who wishes to draft a Ulysses directive, the Minnesota Legislature must make changes to the current advance psychiatric directive statute. It must address the due process and consent concerns described above, and should also add provisions taking advantage of lessons learned from other types of advance directive statutes.

Because Minnesota law is sufficiently similar to the mental health treatment law of other states,²²¹ the adjusted Minnesota statute can serve as a model for other state legislatures. With only a few further changes to accommodate minor differences in state commitment laws, such a statute could be adopted by any state to enable its citizens to draft Ulysses directives.

A. Due Process and Consent

As discussed above, there are two ways in which a legislature might meet the Ulysses patient's need for a quick competency determination. The legislature could provide for an expedited judicial hearing, or it could allow someone other than a judge to establish the patient's competence or incompetence. For some patients who draft Ulysses directives even a one day delay in treatment can have a dramatic impact on the severity of their relapse.²²² In emergencies, judges make medical treatment decisions in hours, but the amenability of the judiciary to additional emergency decisionmaking responsibilities is questionable. The advantage of such an arrangement, however, is that a judge is likely to become familiar with a patient who regularly suffers relapses from the same disease, and will be better able to make a competency assessment.

The other option is to delegate the competency determination to the patient's physicians. When the patient suffers from a mental disease that predisposes her to refuse proffered treatments, such a

²²⁰ The argument that the execution of a Ulysses contract (as distinguished from a statutorily authorized directive) grants the declarant's physician discretion in determining the competency of the patient is likely to fail on anti-slavery, vagueness, and equal protection grounds. See Dresser, *Ulysses and the Psychiatrists*, *supra* note 12, at part III.

Another argument, that the signing of a Ulysses contract reverses the presumption of competence, will fail for similar reasons. Additionally, there is no strong basis in state law for a presumption of *incompetency* once the state has rejected such a presumption for committed patients with mental illnesses.

²²¹ See discussion *supra* part II.A.

²²² See Rosenson & Kasten, *supra*, note 7 at 2-3.

patient could choose in advance the option of physician assessment of competence. Until the next available hearing date,²²³ the patient would permit her physician, with review by a hospital panel, to determine her competence. The legislature could specify use of the three-part Beck competency assessment as the basis for this out-of-court determination.²²⁴ Under such a test the patient can be assured both that the treatment will be given an opportunity to take effect and that eventually she will receive a full competency hearing. This sort of statute would have the effect of establishing, under certain conditions and for a short period of time, a reversal of the presumption in favor of the patient's competence. It would not, however, establish *de facto* incompetence for the time period. The panel of physicians can always find the patient competent again before the judicial hearing.²²⁵

B. Other Concerns

Besides changing the method of competency assessment, the Minnesota Legislature should consider other changes to make the current statute better able to accommodate the needs of patients without weakening the protections afforded those patients. An amendment should include a section requiring that anyone drafting a Ulysses directive have been diagnosed with the recurring illness to be treated under the provisions of the document, and further, that the person have been previously treated with the requested medication or procedure.²²⁶ This requirement grows from a concern about consent: a patient's consent to an unexperienced future course of treatment cannot be sufficiently *informed* consent.

A patient who binds herself to a series of electroconvulsive treatments may not fully understand the commitment that she is making. In normal circumstances she is able to withdraw consent at any time;²²⁷ but under a Ulysses directive she will not have this option. The treatments might be more painful than she anticipated,

²²³ In Minnesota, this interval is ordinarily two weeks. With a showing of good cause it can take up to forty-five days. MINN. STAT. ANN. § 253A.07, subd. 8 (West 1982).

²²⁴ See *supra* notes 121-24 and accompanying text.

²²⁵ Note that the danger of a physician "nursing" a patient into a long period of incompetence does not exist because of the revocation clause. If a physician tried to reset the two week period before a hearing by finding a patient competent, and then finding the patient incompetent again shortly thereafter, the patient could revoke the directive during the period of competence.

²²⁶ A similar requirement is suggested in Dresser, *Ulysses and the Psychiatrists*, *supra* note 12, at 782.

²²⁷ Under Minnesota law, for example, absent a Ulysses directive a physician must withdraw the treatment as soon as the patient voices refusal and until the patient gives competent consent or the physician obtains a court order. See discussion *supra* part II.A.

and she may later regret the forced treatment. Any subsequent attempt to withdraw her consent while incompetent raises real questions about whether the treatment should continue.²²⁸ In contrast, if the patient has already experienced a treatment, the patient is familiar with the nature and side effects of the treatment and is assumed to have determined that the suffering involved is worth the outcome.

The statute should also make clear that the power of attorney can be used to change the treatment directives unless otherwise limited.²²⁹ Many people with mental illnesses will have taken advantage of the durable power of attorney to safeguard children and property, and these patients should know how that power will interact with their advance psychiatric directive. The best alternative to simply providing information in the Ulysses directive statute is to enact a statute excluding revocation of the directive from the powers granted under the power of attorney. The disadvantage of this approach is that it eliminates flexibility.²³⁰ Attempting to provide the drafter with complete information preserves this flexibility at the expense of a small risk that some Ulysses directives will be altered by the holder of a durable power of attorney.

The statute should also contain a section encouraging the patient to give thought to what she wants done if she is discovered to be pregnant while incompetent. Some of the treatments that the patient requested may have an adverse effect on the development of a fetus.²³¹ If the legislature includes mention of this contingency in the statute, the drafter will be reminded of the possibility and can plan accordingly.²³² By requiring an explicit statement by the patient detailing what she wants done in the event of pregnancy, the statute avoids the constitutional problems of living will pregnancy

228 ROBERT M. VEATCH, CASE STUDIES IN MEDICAL ETHICS 309-310 (1977) (describing such a case of questionable application of prospective self-binding to an unexperienced treatment).

229 See discussion *supra* part I.A.2.b.

230 Patients might want to allow revocation of the Ulysses directive by the holder of the power of attorney as a protection against application of the directive by physicians.

231 For example, neuroleptics can cross the placenta and produce damage in the developing fetus. See Michael A. Taylor, *Indications for Electroconvulsive Therapy*, in *ELECTROCONVULSIVE THERAPY* 7, 17 (Richard Abrams & Walter B. Essman eds., 1982).

232 Some living will statutes have tried to deal with this problem by revoking the effect of the living will for the duration of the pregnancy. This is of questionable constitutionality. See *supra* note 49. If it can be upheld, it is another argument for the appointment of a proxy. The proxy can direct that an abortion be performed. The living will then returns to effect, and the removal of life support can proceed.

Where the mother is suffering from a mental illness, the interest of the fetus and of the mother may conflict because of treatments received by the mother. The mother should be encouraged to plan accordingly and, of course, to appoint a proxy.

clauses²³³ and eliminates the uncertainty that results from the absence of any such direction.

Finally, a Ulysses directive statute should contain a provision providing protection against psychiatrists coercing patients into creating such a directive. If the legislature fails to include such a provision, the statute will provide a means for physicians to assume control of treatment decisions. Such a provision must apply at the drafting stage of the directive; requiring a hearing on undue influence, as with a testamentary will, gives the incompetent patient another way to force judicial examination of the medical treatment, subverting the Ulysses directive's advantage of expedience.²³⁴

An anti-coercion provision could be as simple as requiring the patient to consult with an independent psychiatrist on the merits of a Ulysses directive. The statute could also employ one of the safeguards of the Minnesota neuroleptic treatment statute²³⁵ and require approval of the directive by a multidisciplinary hospital review board before the patient signs the directive.²³⁶

CONCLUSION

The right of Americans with mental illnesses to control their treatment while incompetent is developing slowly. The Minnesota advance psychiatric directive statute is a step in the right direction, but it does not successfully meet the needs of all patients with mental illnesses.

Patients with recurring mental illnesses have special needs that require innovative solutions. Such illnesses can be a great burden on the patient, both emotionally and financially; the costs to society are equally as great. The Ulysses directive provides a way of preventing these costs by allowing the patient to choose treatments in advance of a later relapse. Such a document increases the patient's control of her own life and reduces the cost of her illness to both herself and to society.

The Minnesota advance directive statute shows promise for the resolution of some of these problems, but fails to deliver a complete solution for patients with recurrent mental illnesses. This Note has shown how the Minnesota Statute fails in this respect. It has outlined specific procedural problems with the statute and has located the source of these problems in case law. Finally, it has proposed changes to the statute that would give more control over treatment decisions to people with mental illnesses. Such changes would turn

²³³ See *supra* note 49 and accompanying text.

²³⁴ See discussion *supra* part II.B.1.

²³⁵ MINN. STAT. ANN. § 253B.03, subd. 6c (West Supp. 1993).

²³⁶ MINN. STAT. ANN. § 253B.03, subd. 6c(d)(3) (West Supp. 1993).

the Minnesota Statute into a model that legislatures across the country could follow in the drafting of Ulysses directive enabling statutes. This would, in turn, significantly lighten the burden that recurrent mental illnesses now impose on the citizens of all states.

Roberto Cuca[†]

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